

KanCare HCBS All MCO Training

Summer 2016



WELCOME



- Welcome
- Housekeeping items
- Introductions
 - United Healthcare
 - Amerigroup
 - Sunflower Health Plan
 - Kansas Department of Health and Environment
 - Kansas Department of Aging and Disability Services
- Agenda for the day



POLICY UPDATE

State Policy and Rate Changes



The State of Kansas works very closely with the KanCare MCO's to ensure we are made aware of new state policies or changes to current state policies.

- The state and MCO's meet weekly.
- The state and the MCO's coordinate effective dates for any new or changing policies.
- The MCO's provide weekly status updates to the state on progress towards implementing new or changing policy.
- The State and MCO's coordinate to ensure provider notices and bulletins are sent to impacted providers.

Personal Care Services (PCS) & Limitations Policy



- The term PCS has been standardized across the HCBS waiver populations and replaced all previous terms for these services and/or worker. Previous terms being replaced include Personal Services, Personal Care Attendant, Personal Assistant Services, Personal Services Attendant, Attendant Worker, Direct Services Worker, Medical Services Attendant, Supportive Home Care, and Attendant Care Services.
- Billing codes and rates as identified for each HCBS program remain the same.
- PCS is designed to assist elderly and disabled participants in their home and community setting; focusing on Activities of Daily Living (ADLs) such as bathing, grooming, toileting, transferring, and eating and Instrumental Activities of Daily Living (IADL) such as shopping, laundry, housekeeping, and meal preparation.
- Participant's needs are assessed by MCO and identified on the Integrated Service (ISP). The ISP will document authorized service in hours/units and the participant's selected provider.
- Complete policy is located KDADS.ks.gov

Personal Care Services & Limitations



Legally responsible person: typically parent of a minor child or a spouse

Extraordinary Care: exceeds the ordinary care that would be provided to a person without a disability of the same age as determined by the State within reasonable limits that preserve participant choice and takes into consideration supports that would be provided informally or by a third party. PCS will not be approved for ordinary care that the legally responsible person should provide.

Limitation: a Legally Responsible Person shall not be paid to provide PCS or similar services unless one of the four criteria in the State's PCS Policy has been met.

MCO Administration: Each MCO will work with Providers on existing cases to determine next steps

Personal Care Services & Limitations



Capable Person: A person who lives at the same physical address as the member, who has significant relationship with the member, or who is willing and able to provide informal supports in Instrumental Activities of Daily Living. A capable person can include, but is not limited to, a spouse, parent, child, significant other, friend, roommate, or a member of a church or community group.

Limitation: Capable person shall not be paid to provide PCS or similar services for Instrumental Activities of Daily Living (IADLs). This restriction may not apply if the existence of one of the exceptions is present.

Exceptions must be reviewed and approved by MCO.

Even if the Court deems there is no conflict of interest in relation to a capable person developing the ISP and being a paid provider, the CP will still have to follow the new policy.

MCO Administration: Each MCO will work with Providers on existing cases to determine next steps

Enhanced Care Services Policy



- Sleep Cycle Support Services transitioned to new name: Enhanced Care Services (ECS).
- One unit = a minimum of six hours
- Program guidelines, billing code (T2025) and unit limitations (one unit is a minimum of six hours) remain the same.
- ECS offers supervision and non-nursing physical assistance to qualified members during their normal sleeping hours in their place of residence
- Services may include supervision or physical assistance with tasks such as toileting, transferring to and from a wheelchair, mobility and medication reminders.
- The Capable Person and Legally Responsible person policies apply to the Enhanced Care Service.
- Complete policy is located KDADS.ks.gov

IDD/Extraordinary Funding



The State EF Policy requirements, including the following, will apply:

- All requests for Extraordinary Funding must be submitted by the **day or residential provider** requesting the extraordinary rate. The provider must use the standardized EF request tool located on the KDADs website and supply all current and required documentation.
- Annual requests for renewal of Extraordinary Funding must be submitted at least 60 days prior to the expiration of the current extraordinary funding authorization.
- The new State policy requires a financial audit to cost of both Individualized rate the super tier rate.
- If a Member who is approved for Extraordinary Funding moves to a new location and/or to a new provider, the provider must submit a new request within 30 days of the transition. This request must contain the updated, required documentation.
- Any EF requests that do not contain the documentation required by the State EF Policy, or that are not submitted within the required time frame, may be administratively denied.
- The provider cannot deny care due to Extraordinary funding denial.
- The provider may appeal an Extraordinary Funding denial. The appeal must first be submitted to the MCO. A second level appeal may be submitted to KDADs for Administrative Reconsideration.

IDD/Extraordinary Funding:Amerigroup



➤ Amerigroup- Initiating Requests for EF

- **Please submit to :** ksltssidd@amerigroup.com
- **Existing-** All requests for renewals are due 60 days in advance of the expiration of the current EF authorization.
- **New Applications-** All new requests are accepted for members meeting the qualifications as noted in Policy #M2016-044. Provider must note within the application specific criteria met by the member which would qualify the member for EF.

➤ Amerigroup- EF Requests Require the Following Documentation

• **Healthcare Information**

- ✓ MAR -Medication Administration Record
- ✓ Latest laboratory work
- ✓ Sample of health indicators of chronic conditions/problems tracked by the provider (examples- blood pressure, blood sugars, weights, intakes, seizures, etc.)
- ✓ History of Utilization.-List of physician's appointments and reasons for such since the last review, list of hospitalizations/ER visits and reasons for such since the last review.

• **BSP –Behavioral Support Plan**

- ✓ Amerigroup expects to receive summarized and interpreted behavioral data for all targets listed within the BSP.
- ✓ Provider is to note the actions of the team in response to the behavioral fluctuations.
- ✓ It is not necessary to submit data for targets of the BASIS assessment unless these are also targets in the BSP.

➤ Amerigroup- Administrative Letters

- **Authorization Letters** - will be issued when extraordinary funding is approved.
- **Denial Letters** -will be issued when extraordinary funding is denied or terminated.

**The Integrated Service Plan will be updated to reflect EF when approved, denied, or terminated.*

IDD/extraordinary Funding: Sunflower



- **Sunflower Health Plan** may also request additional supporting documentation. This documentation must be submitted within 10 business days of the request.
- **Sunflower Health Plan** Members living within a Shared Living arrangement, within the EF staffing wage sheet and cost calculation, the provider must use the average wage for the provider's other direct care hourly non-exempt employees for that service within that region of the State. If the provider does not employ hourly direct care staff within that region, they may obtain an average direct care staffing wage for that service from other local providers and document, within the staffing wage sheet, how this information was obtained.
- **Sunflower Health Plan** is extending all approved Extraordinary Funding authorizations to the end of each person's birth month. Therefore, the renewal will occur during the same time as the annual assessment and Integrated Service Plan. The 60 day requirement for submitting annual requests will begin 8/1/16 for service plans with start dates in October.
- **Sunflower Health Plan** will issue a provider administrative denial letter for any EF request that was submitted to **Sunflower Health Plan** and initially reviewed between Jan. 1, 2015 and May 31, 2016, for which updated data has been requested and reviewed, and EF is being denied using the current State EF Policy criteria. The letter will contain appeal information. A Notice of Action will not be sent to the Member, as denial of EF does not constitute a service reduction. Pursuant to the State EF Policy, a provider may not reduce needed services to a Member if EF is denied.
- **Sunflower Health Plan** will not require the audit to cost documentation for an EF renewal request until the template for this information has been approved and sent to providers.

IDD/extraordinary Funding: UnitedHealthcare



- **UnitedHealthcare** may also request additional supporting documentation. This documentation must be submitted within 10 business days of the request.
- **UnitedHealthcare** Members living within a Shared Living arrangement, within the EF staffing wage sheet and cost calculation, the provider must use the average wage for the provider's other direct care hourly non-exempt employees within that region of the State. If the provider does not employ hourly direct care staff within that region, they may obtain an average direct care staffing wage from other local providers and document, within the staffing wage sheet, how this information was obtained.
- **UnitedHealthcare** is extending all existing Extraordinary Funding authorizations to the end of each person's birth month. Therefore, the renewal will occur during the same time as the annual assessment and Integrated Service Plan. The 60 day requirement for submitting annual requests will begin 6/1/16 for service plans with start dates in August.
- **UnitedHealthcare** will issue a provider administrative denial letter for any EF request that was submitted to United HealthCare during calendar year 2015, and is being denied using the current State EF Policy criteria. The letter will contain appeal information. A Notice of Action will not be sent to the Member, as denial of EF does not constitute a service reduction. Pursuant to the State EF Policy, a provider may not reduce needed services to a Member if EF is denied.

HCBS Provider Background Check Policy



Initial DRAFT policy issued on 5/24/2016

Summary: All employers and providers are required to maintain documentation that a background check was completed and the employee, contractor or subcontractor has a clear background check to provide direct support and services to vulnerable individuals receiving services through HCBS Programs. To be a qualified provider, individuals and entities shall meet the provider qualifications, including a background check. The background check policy has been standardized for all HCBS programs to ensure consistency, efficiency and effectiveness of background checks for individuals receiving long-term services and supports through HCBS programs.

Kansas participates in the National Background Check Program, which applies to HCBS providers. CMS released additional guidance on background check requirements on June 1, 2015.

- Public Comment: Currently for posted comment
- **Contact:** HCBS-KS@kdads.ks.gov
- **Policy Location:** [https://www.kdads.ks.gov/commissions/csp/home-community-based-services-\(hcbs\)/hcbs-policies](https://www.kdads.ks.gov/commissions/csp/home-community-based-services-(hcbs)/hcbs-policies)



GENERAL ADMINISTRATION

KMAP ID



- If provider is not contracted with KMAP for a specific waiver service, they should not be providing it
- To update - Fill out KMAP Application and Disclosure of Ownership is needed. (To add services/waiver types)

Provider Data



It is critical to make sure all of your provider data is updated with KMAP as well as all 3 MCO's. This will ensure correct claims processing, correct payments and correct notifications. Please make sure you notify all parties in advance or immediately when any of the following information has changed:

- TIN
- NPI
- Address
- Phone numbers
- Email address

***Please make sure you check your individual contract for each MCO for provider specific timely notification requirements**

Recredentialing



MCOs are required by CMS and the State of Kansas to recredential providers every 3 years. It is critical that you return the recredentialing packets with all documents included, for example:

- Credentialing application
- Disclosure of Ownership Statement
- Licensures, Insurance and other required documents

If this information is not returned timely we are required to terminate the provider contract, resulting in a non par status and reduction or denial of payment. If this occurs, the only option to re-join the MCO's network will require new credentialing and obtaining a new executed agreement.

Client Obligation



What is the HCBS client obligation?

The HCBS client obligation is the payment amount the KanCare Clearinghouse determines HCBS recipients must contribute toward payment for their HCBS services. HCBS recipients pay their client obligation each month directly to the care provider assigned the client obligation – typically the provider who delivers the majority of HCBS services to the recipient. The client obligation is deducted from the provider's claims payment each month and the provider is responsible for collecting the client obligation from the HCBS recipient.

Where can I verify client obligation amounts?

Providers can view obligation amounts for KanCare members by logging onto the Kansas Medical Assistance Program's secure website at kmap-state-ks.us.

Client Obligation continued...



How are providers notified about client obligations for the KanCare HCBS recipients they care for?

UnitedHealthcare: Providers are sent a report by the 10th of each month via secure email or fax that lists the names of their KanCare members who have a client obligation along with the amount to collect from each member.

AmeriGroup: When an obligation is initiated through an eligibility determination or is adjusted due to the application or removal of a qualifying medical expense, allocation, or cost of living adjustment (COLA) increase, the appropriate provider(s) and member are notified of the obligation assignment and amount within 5 days of our receipt of the State file; via a letter sent by our internal Long Term Services and Support (LTSS) Staff.

Sunflower: Providers can view and print a report of the client obligation assigned to them for their participants through the Sunflower provider portal. Some participants may have \$0 client obligation indicated.

Person Centered Support Planning



Person-Centered Plan: A support plan with goals that is developed based upon the lifestyle preferences of the member. The Person-Center process details the supports a participant needs and wants including formal and informal supports for achieving goals, addressing barriers, and ensuring choice, independence, integration, and a person-centered focus in the service planning process. The Person-Centered Plan is preferably led by the member, and developed with the member, his/her support team and Care Coordinator.

Integrated Service Plan (ISP): plan that details the approved services and community/natural supports a participant needs in order to remain healthy and safe, and to meet and achieve their Person-Centered Plan goals. The Integrated Service Plan is developed with the member, their support team and Care Coordinator.



Amerigroup TCM Authorization Review

TCM authorizations for waiver members will naturally occur by means of an ISP/Subsequent Reviews and submission of the Choice Form Agreement

➤ TCM Authorizations for Non-Waiver Members

Send to: KSI - Case Specialist/LTSS kscasespec@amerigroup.com

Subject Line: Request for TCM-Auths-OE (OE is for Otherwise Eligible)

Provide us with: (An Excel Spreadsheet is acceptable and encouraged when submitting request for multiple members.)

- Member's Name
- Member ID number or Medicaid number
- Provider Name
- Provider NPI
- Start date of service

*If member is new to the provider, the choice form must be attached

➤ Request an Exception for Additional TCM Authorizations -Authorizations which exceed the annual max of 240 units

Request is entered via :TCM Prior Authorization system located within KAMIS.

Manual - https://www.kdads.ks.gov/docs/default-source/General-Provider-Pages/HCBS/Provider/TCM-Provider-Documents/tcm_pa_request.pdf

**We will not retro date additional TCM authorizations which exceed the maximum allotted 240 units or provide reimbursement for said services that are rendered prior to the date of approval.*

➤ Reviewing TCM Authorizations-You can verify authorization information by logging into the Amerigroup.com and accessing --**Member >Patient 360**

Starting Services

- ✓ Care coordinator completes a functional needs assessment within 7 business days from 834 eligibility file notification
- ✓ Care coordinator & member develop the person centered service plan (PCISP)
- ✓ Authorizations are entered for HCBS services



CLAIM MANAGEMENT

How Do I Submit a Claim for Payment?



- Options
 - Electronic submission (837 claims transaction)
 - Direct submission to the MCO from a medical management system
 - Submission using an EDI vendor
 - Submission directly to the state
 - Website submission
 - KMAP Website
 - MCO Websites
 - Authenticare (HCBS providers)
 - Paper submission
 - Mail to MCO claims processing address

Claims Timely Filing



Each MCO is allowed to set timely filing requirements as part of each individual contract with providers. Please review your individual contract for timely filing requirements.

Claims Outcome & Payment Information



- Provider Remittance Advices (PRA), also known as Explanation for Benefits (EOB) is the primary source for providers to see how a claim was processed.
- Claims submitted to KMAP for routing to the MCO's will get Front End Billing EOB's if KMAP was unable to pass the claim along to the MCO for processing.
- It is critical that providers review and post payments and denials noted on PRA's/EOB timely in order to ensure corrected claims or reconsiderations are submitted within required timelines. Additionally it allows you to quickly resolve any outstanding items and remove dollars from outstanding Accounts receivable reports.
- All 3 MCO's have self service tools on their Websites, Provider Services Call Centers, and Provider Relations staff to assist you with any question regarding how a claim was processed.

What if I need help with a claim?



All 3 MCO's have self service tools on their Websites, Provider Services Call Centers, and Provider Relations staff to assist you with any question regarding how a claim was processed. When reaching out for assistance please make sure you have the following information:

- The MCO claim number
- The members Medicaid ID #
- The date of service on the claim
- Total billed charges
- The Tax ID # or NPI for the provider

If working with one of our call centers or Provider Relations staff, please make sure you note in your file the name of the person you spoke with and the date and time of the call.

How do I submit a corrected claim?



A corrected claim would be needed if the provider determines there was an error on the original claim either by their own internal review or based on how the MCO processed their claim.

- You must indicate a 7 as either the 3rd digit of the Type of bill (UB) or as the frequency code (I500).
- Include the original MCO claim number in the appropriate field on the claim.
- Submit the corrected claim within 365 days of the original paid date, although we strongly recommend submitting corrected claims as quickly as possible.
- Check with the MCO to learn what options are available for submitting corrected claims, i.e. Electronically, paper, etc.

News & Announcements

[Provider Update: TPL Cost Avoidance for HCB& Codes](#)

[CMHC Billing Guidelines](#)

[Discontinuation of TriVadis Health \(formerly Nipro Diagnostics, Inc.\) diabetic supplies](#)

Login

Amerigroup Self Service Portal



Login to "SECURE" Provider Self Service Portal

Amerigroup.com

Public Provider Self Service Portal

Do more online by registering for Provider Self-Service

Through Provider Self-Service, you can:

- File and check the status of medical claims
- Verify eligibility
- Request precertification
- And much more!

To log in, use your Avelity ID and password. If you need an Avelity ID, visit www.Avelity.com to register today.

Visit [Frequently Asked Questions](#) about Avelity for more information.

Join the Amerigroup Network

[Learn about collaborating with us](#)

[Begin Application Process](#)

Announcements, Resources & Documents,
and Credentialing/Contracting Information

Patient 360-Authorizations plus all
inclusive member information

Claims, Appeals, Status, and EDI info

Patient 360

Patient360 is a read only dashboard that will simplify administration through coordinating access to member-centric patient information allowing providers who are part of a patient's care and [...Read More](#)

Use our lookup tool to see if a member is
registered for Patient 360:

All fields required

Last Name:

Member ID:

Date of Birth:

Disclaimer: The clinical data displayed may not reflect all of the services, treatments, drugs, or tests delivered/administered. Access, use, or disclosure of information related to certain sensitive medical services, including but not limited to services related to mental health, reproductive health, pregnancy, HIV status, and drug and alcohol abuse treatment, is strictly limited by federal and state laws. Information about such sensitive services will not be displayed in the tool.

You must read and agree to this statement before proceeding.

By utilizing the Patient360 (Clinical Data Look-up) Tool on this site, you attest that your organization is a healthcare entity that utilizes this information for recognized healthcare, treatment of payment purposes only. In addition, you are confirming that you have a valid

Provider Resources & Documents

- [Behavioral Health & Screening Tools](#)
- [Claims Submission and Reimbursement Policy](#)
- [Clinical Practice Guidelines](#)
- [Disease Management Centralized Care Unit](#)
- [Emergency Transportation Billing](#)
- [EP&DT](#)
- [Find Your Provider Representative](#)
- [Forms](#)
- [Health Home s](#)
- [HPV Education](#)
- [ICD-10](#)
- [Known Issues Log](#)
- [Manuals & Referral Directories](#)
- [Maternal Child Program](#)
- [Medical Management Model](#)
- [Newsletters](#)
- [Pharmacy](#)
- [Quality Management](#)
- [Quick Tools](#)
- [Training Programs](#)

Issues Log

[Manuals & Referral Directories](#)

[Kansas Provider Manual](#)

Ocular Benefits KanCare Manual

Scion Dental Provider Manual

Quick Reference Card

Billing Guide

Kansas Referral Directory

[Home](#)

[Claims](#)

[Submit Claim](#)

[Check Claims Status](#)

[Appeal Claim](#)

[Check Appeal Status](#)

[Forms](#)

[Electronic Data
Interchange \(EDI\)](#)

[Clear Claim
Connection](#)

[Reimbursement
Policies](#)

[Medical](#)

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[Members](#)

[PCP Member Listing](#)

[Member Reports](#)

[Member Health
Assessment](#)

[Health Action Plan](#)

[Personal Disaster
Plan](#)

[Member Rights &
Responsibilities](#)

[Eligibility](#)

[Patient360](#)

[Provider
Education](#)

Sunflower Self Service Website Tools



☐ sunflowerhealthplan.com

Resources available to providers.

For Providers

Request Email Alerts

Provider Login

Join Our Network

Pre-Auth Needed?

Pharmacy Program

Provider Resources

Sunflower provider resources:

- Manuals & Guides
- Bulletins
- Forms
- Practice Guidelines
- Frequently Asked Questions
- Provider/Practitioner Changes
- Helpful Links
- Training
- Claim Explanation Reason Description
- Fraud, Waste and Abuse

Contact Us

- Provider Representative Contacts and Territory Map
- Medical Management Case Management, Regional Map
- Nursing Facility / Intermediate Care Facility Regions

☐ <https://provider.sunflowerstatehealth.com>

The screenshot shows the Sunflower Health Plan provider portal. At the top, there's a navigation bar with icons for Eligibility, Patients, Authorizations, Claims, Messaging, and a user profile for Jacqueline Barber. Below this is a search bar for 'Viewing Claims For' with a dropdown menu showing '453276702' and 'Sunflower Health'. To the right are buttons for 'Upload EDI' and 'Create Claim'. The main section is titled 'Claims' and has tabs for 'Individual', 'Saved', 'Submitted', 'Batch', 'Recurring', 'Payment History', 'My Downloads', and 'Claims Audit Tool'. A 'Filter' button is on the right. The 'Individual' tab is selected. Below the tabs are search filters for 'Date Range' (From 03/23/2016 to 06/23/2016), 'Member' (Last Name: smith, First Name, Member ID), 'Claim' (Claim #, Status: Select..., Ref/Acct Number), and 'Provider' (NPI, Medicaid #). At the bottom are 'Go!' and 'Clear' buttons.

UnitedHealthcare Self Service Website Tools



❑ uhcommunityplan.com

Resources available to providers.

Provider Information	
Claims and Member Information	Electronic Data Interchange (EDI)
Pharmacy Program	Health Home
Reimbursement Policy	Appeals, Grievances and State Fair Hearings Information
Newsletters	Claim Reconsideration and Appeals
Bulletins	Cultural Competency Library
Medicare Part D Educational Materials	Credentialing
Provider Forms	Value Added Benefits for Members
Clinical Practice Guidelines	

❑ unitedhealthcareonline.com

UnitedHealthcare **ONLINE** About Us Contact Us Physician Directory Practice/Facility Profile Help Sign In New User

▼ Patient Eligibility & Benefits ▼ **Claims & Payments** ▼ Notifications/Prior Authorizations ▼ Tools & Resources ▼ Clinician Resources

Welcome to UnitedHealthcare
A resource for physicians and healthcare providers

Link: Your New Online Tools

- Get the information you need with fewer clicks.
- Link replaces Optum Cloud Dashboard
- Use Your Optum ID to sign in to Link and

Claims & Payments Menu:

- [Claim Estimator](#)
- [Claim Reconsideration](#)
- [Claim Research Project](#)
- [Claim Status](#)
- [Claim Submission](#)
- [Electronic Payments & Statements \(EPS\)](#)
- [Fee Schedule Lookup](#)
- [OneNet PPO Pricing Status](#)
- [Outpatient Procedure Grouper \(OPG\)](#)
- [UnitedHealthcare Online All-Payer Gateway](#)

Tools & Resources Menu:

- [EDI Education for Electronic Transactions](#)
- [Forms](#)
- [Health Information Technology](#)
- [Health Resources for Patients](#)
- [Medicare](#)
- [National Provider Identifier](#)
- [News & Network Bulletin](#)
- [Pharmacy Resources](#)
- [Policies, Protocols and Guides](#)
- [Products & Services](#)
- [Reports](#)
- [Training & Education](#)
- [UnitedHealthcare Community Plan Resources](#)



APPEAL & GRIEVANCES

How do I submit a claims appeal?



If you disagree with the reconsideration determination the next step would be to initiate the formal claims appeal process

- Providers must submit an appeal within 33 days from the date of the negative action
- Providers would need to follow the specific appeals process outlined by the MCO (Note: submission process may vary by MCO)
- The MCO must resolve 98% of all appeals within 30 business days
- The provider will receive a written notice from the MCO indicating the outcome of the appeal

Member Appeal Process



- When a decision to deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, a Notice of Action is sent to the member.
- Providers are also informed via written notice of the decision to deny or reduce a service authorization request.
- Member or representative (including Provider acting on their behalf) may file an appeal in response to above actions.
- Member has 30 plus 3 calendar days if mailed from the date of the Notice of Action to file an appeal.
- MCO will resolve standard appeals for termination, suspension, or reduction of previously authorized services within 30 business days after receipt
- Expedited resolution if it is determined the standard resolution time could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

How Do I File for a State Fair Hearing?



All providers have the right to request an administrative fair hearing, also know as a state fair hearing.

- To request a state fair hearing, the provider must send a written request to:
Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327
- The request must specifically request a fair hearing. The request should describe the decision appealed and the specific reasons for the appeal.
- The request must be received by that office within 30 days of the date of the negative action. Providers are given 3 additional days to allow for mailing the state fair hearing request

***Please note provider must follow the MCO appeals process prior to filing for a state fair hearing**



SAFETY MANAGEMENT

Quality of Care & Safety for our Members



- As caregivers and care coordinators it is our responsibility to take steps to identify safety issues for our members and take steps to prevent and/or otherwise minimize the risks.
- Our partnership and good communication is key to ensuring safety issues are identified and managed appropriately.

Member Safety: Medications



- Studies reveal a sharp increase in fatal medication errors in the home over the past 20 years.
- PCS workers should teach members about their medications and associated safety measures:
 - **The Right Patient:** Double-check the label on the pill bottle to make sure name matches patient
 - **The Right Drug:** Double-check label to make sure it is the correct medication in hand. If a weekly pill box is used; make sure you know which pills to use.
 - **The Right Dose:** Before administering a pill, verify its strength and compare to dosage prescribed.
 - **The Right Route:** Route describes the way a medication is taken – make sure you understand how to administer a particular medication.
 - **The Right Time:** Be sure to heed the timing instructions.
 - **Side Effects/Interactions**
- If PCS worker notices that a member is abusing or not taking medication as prescribed, please contact your members care coordinator.



Member Safety: Fire Safety



Did you know...?

- 4x more likely to die in a fire if there is no working smoke alarm
- Common culprits:
 - Cooking accidents
 - Candles
 - Cigarettes
 - Heaters
 - Faulty electrics (appliances, wiring and overloaded sockets)
- 200 Kansans died in a fire-related incident between 2003 and 2007.
- PCS workers should remind patients of need for working fire alarms and general safety measures. Notify Member's Care Coordinator of any identified risks.



Member Safety: Fall Risk



Did you know...?

- Falls were the 2nd leading cause of unintentional injury deaths (behind MVAs) Between 2003 and 2007, 1,082 Kansans died as a result of unintentional falls.
- The highest rate of deaths due to fall occurred among males 75 years and older.
- PCS workers should remind members there are things they can do to prevent falls:
 - Exercise regularly – most important way to lower chances of falling
 - Have the health care provider review medicines even OTC – the way medicines work in the body can change and some meds or combinations can cause sleepiness or dizziness
 - Regular vision check-ups – poor vision can increase chances of falling
 - Make home safer
 - Remove things that can be tripped over from stairs and places where you walk
 - Remove small throw rugs
 - Use non-slip mats in bathtub and shower
 - Improve the lighting in home
 - Wear shoes both inside and outside and avoid going barefoot or wearing slippers.



Member Safety: Firearms/Weapons



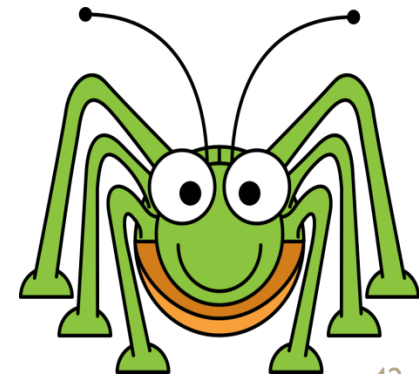
- PCS workers should be aware of weapons in the house and should they ever feel uncomfortable, unsafe or threatened they should always take necessary precautions including calling 911.
- General home safety measures include:
 - Guns should be stored in a well concealed lock box or gun safe
 - Guns should also have a secure locking device – items to block its operation
 - Guns should be kept unloaded and store bullets separately from weapons
 - Any gun owner should teach safety and responsibility to those in the household.

**GUN
Safety**

Member Safety: Pest Control



- Pests and rodents aren't simply a nuisance – they can severely affect health
– i.e. may trigger asthma attacks, viral infections, gastrointestinal issues
- If a provider identifies a Pest control issue, please contact your members Care Coordinator.



Member Safety: Emergency Backup Plan



- Each HCBS member has a detailed ***Emergency Backup Plan*** in the PCISP. Scenarios may include but not limited to the following:
 - Emergency Medical/Behavioral
 - Inclement Weather
 - Evacuation
 - Housing
 - Power Dependent/Power Loss
 - PCS Worker Unavailable
 - 3 Backup Contacts
- The PCS worker should always have a copy and be familiar with the provisions of the plan
 - Member copy
 - FMS copy
 - Ask the Care Coordinator for a copy



CRITICAL INCIDENT MANAGEMENT

Critical Incident Definition



A Critical Incident is defined as a serious, unexpected occurrence involving a member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the member, including death or serious disability, that occurs during the course of a member receiving behavioral health treatment.

Examples include:

- Preventable death
- Physical abuse
- Misuse of medications
- Neglect
- Suicide/Suicide attempt
- Serious Injury

Critical Incidents: Reporting Requirements



- Providers are mandated by law and are responsible for identifying and reporting suspected cases of abuse, neglect or exploitation
- Critical Incidents must be reported to MCO as well as Adult or Child Protective Services
- If the situation involves abuse, neglect or exploitation, notify Adult or Child Protective Services
- Critical Incidents **MUST** be reported as soon as possible, within 24 hours of occurrence.

Adult Abuse Awareness



- **What is abuse?** Any act or failure to act intentionally or recklessly that causes or is likely to cause harm, including: infliction of physical or mental injury; sexual abuse; unreasonable use of physical or chemical restraint, isolation or medication; threat or menacing conduct; fiduciary abuse; or omission or deprivation by a caretaker or another person of goods or services that are necessary to avoid physical or mental harm or illness.
- **What is neglect?** Failure or omission by one's self, caretaker or another person with a duty to supply or provide care, goods or services that are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness.
- **What is exploitation?** Misappropriation of an adult's property or intentionally taking unfair advantage of an adult's physical or financial resources.
- **What is fiduciary abuse?** A situation in which a person who is the caretaker of, or who stands in a position of trust, to an adult, takes, secretes or appropriates his/her money or property for any use or purpose not in the due and lawful execution of the adult's trust or benefit.

Adult Abuse Awareness



When to Report

A report should be made to DCF when:

- ❑ The adult is unable to protect his/her own interest and is in a harmful situation or is in danger of being harmed OR
- ❑ A specific incident or pattern suggests abuse, neglect, exploitation or fiduciary abuse is occurring OR
- ❑ The adult is unable to provide or obtain the services necessary to ensure safety and well-being and to avoid physical and mental harm or illness.

Where and How to Report

- ❑ **Call the Protection Report Center at 1-800-922-5330 or call local law enforcement if a child or adult is in imminent danger.**

AIRS Reported Critical Incidents



- ***HCBS providers are required to report adverse incidents to KDADs via the Adverse Incident Reporting System (AIRS) Portal***
 - ✓ Clinical team begins follow-up within 48 hours
 - ✓ Care coordinator may contact the member, family, responsible party/guardian, PCP, TCM, & any provider
 - ✓ Suspected abuse, neglect, or exploitation (ANE) is reported to APS
 - ✓ Suspected fraud is reported to Fraud Waste & Abuse



FRAUD, WASTE & ABUSE

Fraud, Waste, and Abuse Definitions



The following definitions generally apply to the scope of activities performed:

- ❑ **Fraud** is knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. 18 U.S.C. § 1347.
- ❑ **Waste** is the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a health care benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.
- ❑ **Abuse** includes actions that may, directly or indirectly, result in unnecessary costs to a healthcare benefit program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between “fraud” and “abuse” depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.

Examples of Fraud and Abuse



Administrative or Financial

- Kickbacks
- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent third party liability reporting

Member Fraud or Abuse Issues

- Fraudulent/Altered prescriptions
- Card loaning/selling
- Eligibility fraud
- Failure to report third party liability/other insurance

Misrepresenting Services Provided

- Billing for services or supplies not rendered
- Misrepresentation of services/supplies
- Billing for higher level of service than performed

Falsifying Claims/Encounters

- Alteration of a claim
- Incorrect coding
- Double billing
- False data submitted

Fraud, Waste, and Abuse Reporting



Suspect provider or member practices may be reported:

- Amerigroup at 757-518-3633 or email www.amerigroup.silentwhistle.com or corpinvest@amerigroup.com
- Sunflower at 800-345-1642
- UnitedHealthcare Community Plan at 866-242-7727

State of Kansas Attorney General's Medicaid Fraud Control Unit at 785-368-6220.

If you have any questions pertaining to FWA, please contact:

- Amerigroup's Chief Compliance Officer: 757-473-2711 or email ethics@amerigroup.com
- Sunflower's Compliance Director, Carmen Mills, at camills@sunflowerhealthplan.com
- UnitedHealthcare's Compliance Officer, Crisha Warren, at crisha.warren@uhc.com



VALUE ADDED SERVICES

Amerigroup HCBS Value Added Services

*Value Added Benefit Claims should be submitted via KMAP, Availity, or a Paper Claim. The following codes are not currently configured into the EVV/ Authenticare System.

- **Respite care for members in the Frail Elderly (FE) waiver program** who do not live alone or in an assisted living, nursing facility, group home or similar setting: Amerigroup Kansas offers up to 56 hours of respite care per calendar year.
Providers must bill S5151. One unit = 15 minutes- \$3.00 per unit
- **Extra respite care for members in the Intellectual/Developmental Disabilities (I/DD) waiver program** who do not live alone or in an ICF/MR, assisted living, nursing facility, group home or similar setting: Amerigroup Kansas offers up to 15 extra units of overnight respite care per calendar year.
Providers must bill S5151. One unit = one night- \$78.30 per unit
- **Extra respite care for members in the Autism waiver program** who do not live alone or in an ICF/MR, assisted living, nursing facility, group home or similar setting: Amerigroup Kansas offers up to 24 extra hours of respite care per year.
Providers must bill S5151. One unit = 15 minutes - \$3.00 per unit
- **Extra personal assistant services for members in the I/DD waiver program:**
Amerigroup Kansas offers up to three extra days of personal assistant services.
Providers must bill S9125. One unit = 15 minutes- \$2.64 per unit

Amerigroup **SSI & HCBS** Value Added Services

- **Free Rides** to community health events
- **Extra Over-the-Counter Medicines** a **\$10** once a month mail order
- **Free Caregiver Transportation** to provider appointments
- **In-Home Pest Control** for homeowners up to **\$500** per calendar year

Amerigroup **All Members** Value Added Services

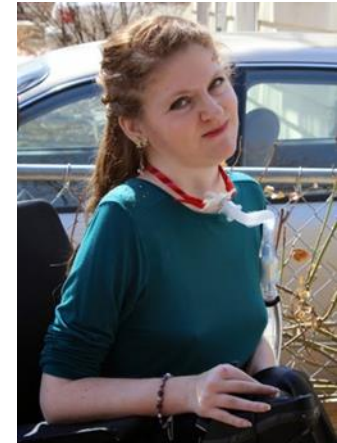
**Age criteria and/or medical conditions must be met to qualify*

- **Dental care** for adults – two free cleanings per year
- **Free SafeLink* mobile phone** with 350 free monthly minutes, plus 200 bonus lifetime minutes and unlimited text
- **\$10, \$15 or \$25 in debit card credits** for over-the counter items when you get certain health checkups or screenings
- **Free stop-smoking program** for adults 18 and older
- **Weight Watchers®** for adults who qualify
- **Free Healthy Living Coaching** for families with kids ages 7-13 who qualify
- **Hypoallergenic Bedding** for people with asthma, allergies, and chronic respiratory or pulmonary conditions up to a **\$100** one-time credit

Sunflower Value Added Services

Specifically for Members in HCBS

- Respite- I/DD and FE
- Hospital Companion- I/DD
- Practice Dental and Medical Escorts- I/DD



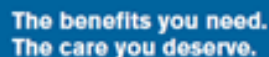
Others Commonly Utilized

- Adult Dental
- CentAccount Healthy Rewards
- MemberConnections
- Pharmacy Review & Disease Management



UnitedHealthcare
COMMUNITY & STATE

-
- Health Care Visits**
Parents can see the child's recommended health care visits.
- Knowing My Plan**
These activities reward a member for things like confirming their Primary Care Provider.
- Daily Health**
Members can earn points for everyday healthy activities, like brushing teeth and eating nutritious meals.
- What's New**
Learn about new opportunities to earn points for healthy activities.



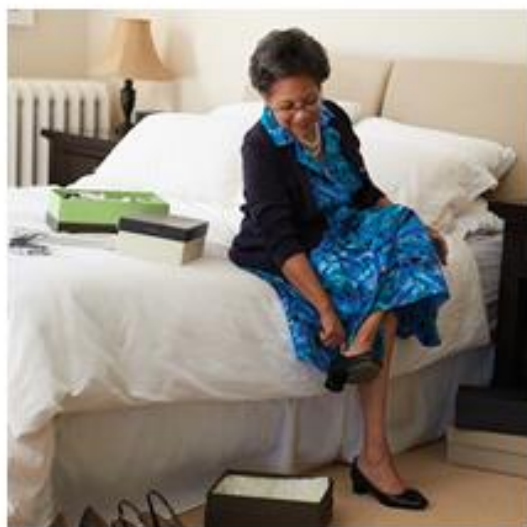
Los beneficios que usted necesita. Los cuidados que usted merece.

- **Pest Control:** HCBS Waiver members who own their home are eligible for Pest Control Services.
- **Denture Benefit:** FE Waiver Members are eligible for a full set of dentures

Value Added Benefits: UnitedHealthcare

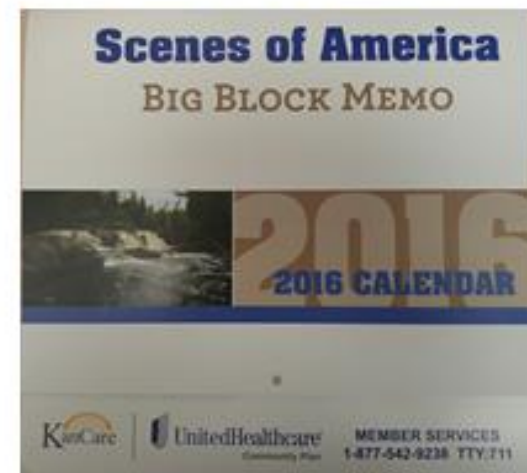


Frail Elderly Members



For our frail elderly members:

- Denture – Full Set
- Home Helper Catalog Item
- Parks and Recreation Activities
- Adult Briefs
- Wellness Calendar



Value Added Benefits: UnitedHealthcare



**For Members with Intellectual or
Developmental Disabilities**



**For those members with intellectual or
developmental disabilities:**

- Transportation to Job Related Activities
- Respite Care

Questions?

